REPORT TO THE TWENTY-THIRD LEGISLATURE
STATE OF HAWAII
2006

PURSUANT TO S.C.R. 197, SD1, REQUESTING THE DIRECTOR OF HEALTH TO CONVENE A MEDICAL MARIJUANA WORKING GROUP TO MAKE RECOMMENDATIONS TO IMPROVE HAWAII'S MEDICAL MARIJUANA PROGRAM

PREPARED BY:

DEPARTMENT OF HEALTH
STATE OF HAWAII
DECEMBER 2005

TABLE OF CONTENTS

REPORT TO THE LEGISLATURE
SUBMITTED BY
THE DEPARTMENT OF HEALTH
IN RESPONSE TO S.C.R. 197 SD1, REQUESTING THE DIRECTOR OF HEALTH TO CONVENE A MEDICAL MARIJUANA WORKING GROUP TO MAKE RECOMMENDATIONS TO IMPROVE HAWAII'S MEDICAL MARIJUANA PROGRAM

PURPOSE

This report is submitted in response to S.C.R. 197 SD1,[1] which requests that the Director of Health convene a Medical Marijuana Working Group to make recommendations to improve Hawaii's Medical Marijuana Program.

WORKING GROUP COMPOSITION

The working group included the following members:[2]

Michelle R. Hill, Deputy Director
for Behavioral Health Administration
Department Health

Keith Kamita, Administrator
Narcotics Enforcement Division
Department of Public Safety

Keith Y. Yamamoto, Chief
Alcohol and Drug Abuse Division
Department of Health

Jeanne Ohta[3]
Executive Director
Drug Policy Forum of Hawaii

Jim Lucas, Registered Qualifying Patient in the Medical Marijuana Program

BACKGROUND

Act 228, Session Laws of Hawaii (SLH) 2000,[4] relating to the medical use of marijuana, allows for the acquisition, possession, cultivation, use, distribution, or transportation of marijuana and paraphernalia relating to the administration of marijuana to alleviate the symptoms or effects of a

[1] See Appendix.

[2] S.C.R. 197 SD1 specifies that the Medical Marijuana Working Group be composed of: (1) a representative from the Department of Public Safety; (2) a representative from the Department of Health; (3) a representative of the Drug Policy Forum of Hawaii; and (4) a registered qualifying patient currently in the Medical Marijuana Program.

[3] See dissenting view on page 11.

[4] S.B. 862 SD2 HD1 was signed into law on June 14, 2000 and codified as Part IX of Chapter 329, HRS.

qualifying patient's debilitating medical condition when a patient's physician provides written certification stating that in the physician's professional opinion, the qualifying patient has a debilitating medical condition and the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient.

The Act in part required that the Department of Public Safety (PSD) promulgate rules to implement a program to register all qualifying patients and primary caregivers authorized by their physicians to utilize marijuana for medical purposes. The Act did not appropriate any additional funding for PSD to implement the program, nor did it address the use of fees collected to supplement the Narcotics Enforcement Division (NED) operation of the program.

On December 22, 2000, PSD held a public hearing on the proposed rules for the medical use of marijuana. On December 28, 2000, the rules[5] were signed by the Governor, and on January 9, 2001, the first certificate was issued by NED.

Act 165, SLH 2002[6] amendments to Section 329-59, Hawaii Revised Statutes (HRS), authorized PSD to deposit fees collected from the Medical Use of Marijuana Program into the Controlled Substance Registration Revolving Fund and appropriated funds ($10,000) for equipment and other current expenses to implement the program. NED presently utilizes Special and General Funds to operate the program. NED presently must dedicate one Clerk Typist II position to process the applications and answer calls from patients and physicians relating to the Medical Use of Marijuana Program. The fees collected are inadequate to pay for the program and the $10,000 authorized is utilized primarily for supplies and postage.

During the 2005 Session, S.B. 128 was introduced to amend definitions and procedures relating to the program and to transfer the Medical Use of Marijuana Program from the Department of Public Safety, Narcotics Enforcement Division to the Department of Health. The bill was held and S.C.R. 197 SD1 was adopted, requesting that the Director of Health convene a working group to make recommendations to improve Hawaii's Medical Marijuana Program.

DISCUSSION

The Medical Use of Marijuana Act allows patients to use marijuana upon recommendation by licensed physicians to cope with debilitating medical conditions. The Act removes the threat of criminal penalties under State laws for patients to use marijuana medicinally and requires that physicians be licensed pursuant to Chapter 453 and Chapter 460, HRS. Although the Hawaii law provides protection against arrest and prosecution by State or local authorities, arrest or prosecution by federal authorities is not precluded.[7]

---

[5] Title 23, Chapter 202, Hawaii Administrative Rules.

[6] H.B. 703 HD 1, SD 2 was signed into law on June 18, 2002.

[7] On April 30, 1997, the U.S. District Court issued a preliminary injunction in Conant et al v. McCaffrey allowing physicians in California to recommend marijuana without fear of criminal prosecution in instances where a bona fide patient-physician relationship exists and action is not made to further an illegal objective. In Gonzales v. Raich, the Supreme Court (on June 6, 2005) held that Congress's Commerce Clause authority warranted regulation and prohibition of local cultivation and personal use of marijuana, even when in compliance with state law.

The following tables illustrate participation in the Medical Marijuana Program. The first table shows the number of patients registered from the January 2001 inception of the program through October 31, 2005. The second table presents current data on the distribution of patients, caregivers and physicians by island.

Medical use of marijuana patients by year and island (as of October 31, 2005)

	2001	2002	2003	2004	2005
Hawaii	106	286	418	928	1517
Kauai	72	169	244	341	404
Lanai	0	0	0	2	4
Maui	19	57	109	253	652
Molokai	0	0	0	5	11
Niihau	0	0	1	5	5
Oahu	58	107	131	253	332
TOTAL	**255**	**619**	**903**	**1787**	**2925**

In the five-year period since commencing operations, the Medical Use of Marijuana Program has had a ten-fold increase in participation. The percentages for participation by island as of October 31, 2005 are as follows: Hawaii - 51.9% (1517), Kauai - 13.8% (404), Lanai - 0.1% (4), Maui – 22.3% (652), Molokai – 0.4% (11), Niihau - 0.2% (5), and Oahu - 11.4% (332).

Registered patients, caregivers and physicians by island (as of October 31, 2005)

	PATIENTS	CAREGIVERS	PHYSICIANS*	
			ON-ISLAND	OFF-ISLAND
Hawaii	1517	165	30	12
Kauai	404	47	16	7
Lanai	4	1	0	3
Maui	652	64	29	3
Molokai	11	2	0	7
Niihau	5	2	0	4
Oahu	332	61	45	8
TOTAL	**2925**	**342**	**120**	**44**

*Patients' physicians may practice on the same or different island where the patient resides.

As shown above, 342 patients or approximately 12% of the patients statewide have caregivers. According to NED, most physicians participating in this program have an average one to five patients, however, there are a few physicians who exceed 100 patients each.

Inquiries received on Medical Use of Marijuana Program. The Administrator for the Narcotics Division reported that during Fiscal Year 2004-05, the Narcotics Enforcement Division's (NED) registration staff handled 4,415 administrative transactions for the registration of patients in the Medical Use of Marijuana Program, with 4 processing errors and 0 complaints. The NED's Registration Section has decreased the time required to process a controlled substance, regulated chemical or medical marijuana registry certificate to within five days, although State

administrative rules require that the processing of these certificates be accomplished within 60 days.

In an informal sampling, the Drug Policy Forum of Hawaii[8] tabulated inquiries received during the period between the Working Group's meeting on October 26, 2005 and November 23, 2005. The organization received 2 phone calls and 3 e-mails inquiring about the registration process. Of the inquiries received, one of the callers was a medical marijuana patient from the mainland who needed information on the Hawaii medical marijuana program and who was in the process of transferring medical records from a mainland physician to a Hawaii physician.

Procedures for Patient and Physician Participation and Operation of the Medical Use of Marijuana Program. Under present procedures, the patient is required to: (1) make an appointment for an office visit with the physician, who diagnoses a "debilitating medical condition" and recommends the medical use of marijuana; (2) pay the $25 fee which the physician encloses and sends with the patient's application; and (3) pick up physician signed registry identification card which is used for verification by law enforcement.

While it has been suggested that posting the patient registration forms on the NED website so that patients may be convenient for some patients (+), there are also concerns (-) with respect to management of the Medical Use of Marijuana Program.

+ Electronic access to forms allows for easy access for the consumer.
+ The number of steps a patient must take to obtain a certificate is reduced for the patient.
+ The patient's completion of the form reduces the number of physician actions and reduces possibility of culpability in 'aiding and abetting' a patient in obtaining marijuana, which is a Schedule I controlled substance.
- Having the patient fill out the registration form for the physician's signature diverges from the intent that a physician recommending the medical use of marijuana requires a bona fide patient-physician relationship.
- Physicians have access to forms which can be duplicated (i.e., xeroxed) once NED sends the form via fax, e-mail or surface mail.
- Submission of fraudulent applications may become unwieldy if forms are readily accessible; a commensurate increase in program oversight responsibilities and costs – including an increase in fees currently used to operate the program – should be expected. Similarly, the current 5-day turnaround time would increase as verification of information submitted would require more time.

[8] The Drug Policy Forum of Hawai'i (DPFH) is a non-profit organization founded in 1993 to encourage the development of effective drug policies that minimize economic, social, and human costs, and to promote the consideration of pragmatic approaches to drug policy based on: scientific principles, effective outcomes, public-health considerations, concern for human dignity, and enhancing the well-being of individuals and communities.

The Drug Policy Forum of Hawai'i sponsors local, national, and international drug-policy professionals to present seminars on such topics as: effective drug education (10/98), medicalizing U.S. drug policy (2/98), medical use of cannabis (1/98, 2/97, 4/95), the hidden costs of women in prison (11/97), a pragmatic model of harm reduction (5/97), and the connection between "ice" and violence (5/96). DPFH also presents films and videos, maintains a reference library on drug policy, acts as a resource for the media on drug-policy issues, sustains an active speaker's bureau, and publishes a bi-monthly newsletter.

Physicians' participation in Medical Use of Marijuana Program. Approximately 160 licensed physicians in the State participate in the Medical Use of Marijuana Program. Of this total, however, participating physicians – ophthalmologists, neurologists, oncologists, physicians engaged in pain management, family practitioners who treat AIDS patients – are more likely to be in practices that would treat patients meeting the "debilitating medical condition" criteria specified in the law.

The Working Group also reviewed the step-by-step process from a physician's perspective. After diagnosing a patient as having a debilitating medical condition, the physician certifies in writing that the potential benefits of the medical use of marijuana would likely outweigh the health risks for the patient. The process to register the patient is as follows:

- The physician obtains the application form (which can be duplicated) from NED via fax, email or regular mail;
- The form is completed and sent with the patient's fee of $25 to NED;
- NED verifies the information submitted and sends the patient's card to the physician; and
- Upon receipt, the physician signs the card and gives it to the patient.

It has been suggested that one of the barriers to increasing physicians' participation is overcoming their concern about prosecution based on federal law, which overrides the State's medical marijuana law. Before changes to the program are considered, however, reasons for non-participation by physicians need to be ascertained. The working group discussed means by which the number of participating physicians might be increased:

- NED's present education of physicians on policies and procedures of the Medical Use of Marijuana program could be expanded;
- A survey of physicians could be conducted to learn the basis for their (non)participation in the program; and/or
- The Legislature could convene physicians to elicit their views as practitioners and "consumers" in the Medical Use of Marijuana Program.

Department of Public Safety, Narcotics Enforcement Division Website. Currently, items posted on the PSD/NED website are as follows:

- Application for Controlled Substances;
- Physician's Assistant Application for Controlled Substances;
- Medical Marijuana Patient Information; and
- Medical Marijuana Physicians' Guidelines Form A.

A copy of the Drug Policy Forum of Hawaii pamphlet entitled, *The Medical Use of Marijuana: A Guide to Hawai`i's Law for Physicians, Patients and Caregivers* which was provided to the Narcotics Enforcement Division, has been forwarded to the Department of the Attorney General for review.

NED is scheduled for upgrading of the agency's computer equipment. Changes – including changes to the webpage – will be phased in as resources become available. By the end of 2005, the updated website will have a "restricted" area within the site which will enable physicians to print out forms. As previously stated, current procedures already allow physicians to submit duplicated (i.e., xeroxed) forms.

Placement of the Medical Use of Marijuana Program. Despite perceptions, the transfer of the Medical Use of Marijuana Program to the Department of Health (DOH) from the Department of Public Safety (PSD) would not reduce the level of oversight. Current procedures for the program would still be followed: DOH would be required to verify physicians' licensure, as well as their authority to prescribe scheduled drugs – functions that require the expertise that resides within the Narcotics Enforcement Division.[9] In addition, a system within DOH that operates "24/7" would have to be established to ensure that law enforcement officers are able to verify a patient's valid use of marijuana for medical purposes.

Department of Health. As specified in Section 26-13, HRS, the Department of Health is responsible for administering programs designed to protect, preserve, care for, and improve the physical and mental health of the people of the State. The Department's programs include the administration and enforcement of matters and laws of public health of the State, including the State Hospital, but excluding assistance and care for the indigent and the medically indigent.

The priorities of the Hawaii State Department of Health are guided by the following:

- The Department implements and maintains the three core functions of public health: assessment, policy development and assurance.

  Assessment. Regularly and systematically collect, assemble, analyze and make available information regarding the health of the community, including statistics on health status, community health needs and epidemiologic and other studies of health problems.

  Policy development. Serve the public interest in the strategic development of comprehensive public health policies by promoting use of the scientific knowledge base in decision-making about public health and by leading in developing public health policy.

  Assurance. Assure that services necessary to achieve agreed upon goals are provided, either by encouraging actions by other entities (public or private sectors), by requiring such action through regulation, or by providing services directly. Assure that public health agencies involve key policy makers and the general public in determining a set of

[9] The functions and authority for scheduling of controlled substances exercised by the Department of Health were transferred to the Department of Public Safety in 1990.

high-priority personal and community-wide health services that governments will guarantee should include subsidization or direct provision of high-priority personal health services for those unable to afford them.

- The Department is guided by the ten essential public health services and the nation's Healthy People objectives.

    - *Monitor* health status to identify community health problems.
    - *Diagnose and investigate* health problems and health hazards in the community.
    - *Inform, educate and empower* people about issues.
    - *Mobilize* community partnerships to identify and solve health problems.
    - *Develop policies* and plans that support individual and community health efforts.
    - *Enforce laws* and regulations that protect health and ensure safety.
    - *Link people* to needed personal health services and assure the provision of health care when otherwise unavailable.
    - *Assure* a competent public health and personal health care workforce.
    - *Evaluate* effectiveness, accessibility and quality of personal and population-based health services.
    - *Research* for new insights and innovative solutions to health problems.

- The Department directs resources at those problems that pose the greatest risk to the public's health and the environment.

- The Department balances competing viewpoints and interests.

Department of Public Safety. The Department of Public Safety is responsible for the formulation and implementation of state policies and objectives for correctional, security, law enforcement, and public safety programs and functions, for the administration and maintenance of all public or private correctional facilities and services, for the service of process, and for the security of state buildings.

As stated in Section 26-14.6, HRS, in 1990, the Narcotics Enforcement Division was transferred from the Department of the Attorney General to the Department of Public Safety; and the functions and authority exercised by the Department of Health pursuant to Chapters 329 and 329C (with the exception of Sections 329-2, 329-3, and 329-4(3) to (8)), were transferred to the Department of Public Safety.

Act 44, SLH 2004, added to the department's functions the responsibility to coordinate drug abatement efforts of the communities with the State, counties, and community agencies, by: (1) facilitating sharing of resources and information; (2) providing technical support for community mobilization groups; (3) establishing community action plans for drug education, awareness, and prevention; and (4) facilitating problem solving in the delivery of law enforcement services by state and local agencies to the community.

Narcotics Enforcement Division. The Narcotics Enforcement Division (NED) is subsumed within the Department of Public Safety, Law Enforcement Division. The Division serves and

protects the public by enforcing laws relating to controlled substances and regulated chemicals. NED is responsible for the registration and control of the manufacture, distribution, prescription, and dispensing of controlled substances and precursor or essential chemicals within the State.

NED is also responsible for assuring that pharmaceutical controlled substances are used for legitimate medical purposes. The Division registers all persons who handle controlled substances in the State, including those who work at methadone clinics.

NED enforces the requirements of the Uniform Controlled Substances Act (Chapter 329, HRS) and the Medical Use of Marijuana Act (Chapter 329, Part IX, HRS; Title 23, Chapter 200, Hawaii Administrative Rules).

Drugs are classified or scheduled according to the potential danger that a particular drug presents to a potential user, both in terms of toxicity and potential for abuse. The schedules are numbered from Schedule I through V, with Schedule I presenting the highest risk –

> *Schedule I* substances are those that have no accepted medical use in the United States and have a high abuse potential. Some examples are heroin, marijuana, lysergic acid diethylamide (LSD), cocaine and methamphetamine.
>
> *Schedule II* substances have a high abuse potential with severe psychic or physical dependence liability. Schedule II controlled substances consist of certain narcotic, stimulant and depressant drugs. Some examples are opium, morphine, codeine, levo-alpha-acetylmethadol (LAAM) and methadone.
>
> *Schedule III* substances have an abuse potential less than those in Schedules I and II, and include compounds containing limited quantities of certain narcotic drugs and non-narcotic drugs such as acetaminophen with codeine and hydrocodone with aspirin. Anabolic steroids are included in Schedule III unless specifically excepted or listed in another schedule.
>
> *Schedule IV* substances have an abuse potential less than those in Schedule III and include such drugs as barbital, phenobarbital and fenfluramine.
>
> *Schedule V* substances have an abuse potential less than those listed in Schedule IV and consist primarily of preparations containing limited quantities of certain narcotic and stimulant drugs generally for antitussive, antidiarrheal and analgesic purposes.

A written prescription is required for substances in Schedule II and must be signed by the physician. The refilling of a Schedule II prescription order is prohibited. A prescription order for substances in Schedules III and IV may be issued either orally or in writing to the pharmacist and may be refilled if so authorized on the prescription. However, the prescription order may only be refilled up to five times within six months after the date of issue. After five refills or after six months, a new prescription order is required either orally or in writing from the physician.

Physicians who administer, prescribe or dispense any controlled substance must be registered with the DEA. The registration must be renewed every three years and the certificate of registration must be maintained at the registered location and kept available for official inspection.

A prescription for a controlled substance may be issued by a physician, dentist, podiatrist, veterinarian or other registered practitioner who is: authorized to prescribe controlled substances by a jurisdiction in which the physician is licensed to practice; and either registered under the Controlled Substances Act or exempted from registration.

FINDINGS AND RECOMMENDATIONS

The following findings and recommendations are submitted pursuant to S.C.R. 197 SD1.

Findings on patient and physician participation and program operation. In the five-year period since commencing operations, the Medical Use of Marijuana Program has had a ten-fold increase in participation. Although there are a few physicians who exceed 100 patients each, most physicians participating in this program have an average one to five patients.

Recommendation. Before changes to the program are considered, reasons for non-participation by physicians need to be ascertained. The working group concurred that to increase the number of participating physicians:

- NED's present education of physicians on policies and procedures of the Medical Use of Marijuana program should be expanded;
- A survey of physicians should be conducted to learn the basis for their (non)participation in the program; and/or
- The Legislature should convene physicians to elicit their views as practitioners and "consumers" in the Medical Use of Marijuana Program.

Findings on Department of Public Safety website. NED is scheduled for upgrading of its computer equipment. Changes – including changes to the webpage – will be phased in as resources become available. By the end of 2005, the updated website will have a "restricted" area within the site which will enable physicians to print out forms, including forms required for participation in the Medical Use of Marijuana Program. As previously stated, current procedures already allow physicians to submit duplicated (i.e., xeroxed) forms.

Recommendation. The Departments of Health and Public Safety recommend implementation of NED's computer systems upgrades as planned.

Findings on the appropriate placement of the Medical Use of Marijuana Program. The functions and authority for scheduling of controlled substances exercised by the Department of

Health were transferred to the Department of Public Safety in 1990. Despite perceptions, the transfer of the Medical Use of Marijuana Program to the DOH would not reduce the level of oversight. Current procedures for the program would still be followed: DOH would be required to verify physicians' licensure, as well as their authority to prescribe scheduled drugs – functions that require the expertise that resides within the Narcotics Enforcement Division. In addition, a system within DOH that operates "24/7" would have to be established to ensure that law enforcement officers are able to verify a patient's valid use of marijuana for medical purposes. Transfer of the Medical Use of Marijuana Program from the Department of Public Safety to the Department of Health would have substantial cost implications, including but not limited to, added personnel and operating costs.

Recommendation. No action is necessary as the functions to operate the program reside with the currently assigned agency. Transfer of the program would incur substantial additional costs and increase fees to be borne by patients.

DISSENTING VIEW

The dissenting view on pages 11 through 16 expresses the view of Working Group member Jeanne Ohta, Executive Director for the Drug Policy Forum of Hawaii.

REPORT TO THE LEGISLATURE

DISSENTING VIEW

SUBMITTED BY
JEANNE OHTA, EXECUTIVE DIRECTOR
THE DRUG POLICY FORUM OF HAWAI'I

REQUESTING THE DIRECTOR OF HEALTH TO CONVENE A MEDICAL MARIJUANA WORKING GROUP TO MAKE RECOMMENDATIONS TO IMPROVE HAWAII'S MEDICAL MARIJUANA PROGRAM

SCOPE OF THE WORKING GROUP

Although SCR 197 SD1 requested the Director of Health to convene a working group "to make recommendations to improve Hawaii's Medical Marijuana Program," the scope of the work as performed was narrowly defined to: (1) a discussion of the contents of the Narcotics Enforcement Division's web page and (2) a discussion on which department should administer the program.

Other recommendations from SB 128 to improve the program were not discussed. Among those recommendations were:

- Revising "adequate supply" from three mature and four immature marijuana plants to eliminate the mature and immature designations and allow for seven total plants.
- Increasing the number of patients that a caregiver is allowed to care for from one to three patients.
- Increasing the certifications' validity from one year to two years or for a shorter time as determined by the certifying physician.

WORKING GROUP COMPOSITION

The working group would have benefited from the inclusion of Department of Health representatives who work in areas where their constituents participate in Hawaii's Medical Marijuana Program, e.g. the HIV/AIDS branch; most members present were either not familiar with the program or do not work with populations who would benefit from the program.

FINDINGS AND RECOMMENDATIONS

Findings on patient and physician participation and program operation. Since the medical marijuana program was initiated in 2000 only 2,925 patients are reported as having received authority for medical use of marijuana. Of these, only 332 were from the island of O'ahu, whose population is around 876,000, about three times the combined population of all the other Hawaiian Islands. This disparity does not suggest that there were fewer Hawai'i patients with debilitating conditions on O'ahu who could have benefited from the use of medical marijuana, but that many more O'ahu residents with such severe qualifying conditions were deprived of the opportunity to be certified for

medical marijuana use.[10] There is, of course, no reason whatsoever to believe that O'ahu residents suffer far fewer "debilitating conditions" per capita than their fellow citizens on the neighbor islands. And there is no reason whatsoever to believe that the difference in incidence of certifications is a result of improper certifications on the neighbor islands. The conclusion that must follow, therefore, is that large numbers of O'ahu citizens for whom medical marijuana would help to relieve debilitating conditions have been deprived of that help by a failure of certification.[11]

The only rational reason why so many fewer patients were certified on O'ahu is that O'ahu physicians have been unwilling or reluctant to seek certification on behalf of their patients. While even the anecdotal evidence is meager, the fact that a highly competent oncologist at Kaiser expressed unwillingness to engage in certification for the benefit of a 74 year old cancer patient for whom he had just diagnosed a deadly form of cancer with a prognosis of not more than two or three months of survival strongly suggests that the physician's fear of consequences ***to him*** – such as losing his DEA license – was the cause of his reluctance. Indeed, he agreed that marijuana might help the patient. Kaiser, moreover, has indicated via memorandum to their physicians in the early years of the program that it is permissible for them to certify patients for the medical marijuana program. That such a medical expert, well placed in the O'ahu medical community, acted in that manner strongly suggests that there is a culture among physicians on O'ahu who deal in such debilitating conditions to avoid such risks to them. And contrary to the recommendations of the majority, there is virtually no likelihood that this information will reveal itself if O'ahu physicians are "surveyed" or if they are called to testify on their views "as practitioners and 'consumers' in the Medical Use of Marijuana Program." ***Their fear of being caught up in a program which could result in their being charged with a violation of the Federal Controlled Substance laws is something they will not publicly admit in a survey or in testimony***.

It is also clear that having to deal directly with the Narcotics Enforcement Division (NED), which as the writers of the majority report correctly note "is . . . responsible for assuring that pharmaceutical controlled substances are used for legitimate medical purposes" and which "enforces the requirements of the Uniform Controlled Substances Act" – in short which has the power to take away a physician's license to use controlled substances and, in effect, to put him or her out of business – may create fear or even paranoia among physicians which could lead them to remove themselves from activities which, in their minds, could give rise to adverse enforcement action against themselves or could simply call attention to themselves from the enforcing agency, the NED.

Furthermore, those physicians who have access to attorneys will understand that if, in certifying their patients pursuant to our Medical Marijuana law, they conduct activities beyond the minimum provided in the Conant v. McCaffrey case, they could be charged

[10] That is, about 335,000 residents on the neighbor islands produced 2,593 persons certified for medical marijuana use while about 876,000 residents on O'ahu produced only 332 such persons.

[11] If the same percentage of persons who were certified on the neighbor islands were certified on O'ahu, about 7,000 would have been certified on O'ahu instead of 332.

with “aiding and abetting” a violation of the controlled substance law. In Conant the Ninth Circuit Court of Appeals said:

> The government on appeal stresses that the permanent injunction applies "whether or not the doctor anticipates that the patient will, in turn, use his or her recommendation to obtain marijuana in violation of federal law," and suggests that the injunction thus protects criminal conduct. A doctor's anticipation of patient conduct, however, does not translate into aiding and abetting, or conspiracy. A doctor would aid and abet by acting with the specific intent to provide a patient with the means to acquire marijuana. See Gaskins, 849 F.2d at 459. Similarly, a conspiracy would require that a doctor have knowledge that a patient intends to acquire marijuana, agree to help the patient acquire marijuana, and intend to help the patient acquire marijuana. See Gil, 58 F.3d at 1423. Holding doctors responsible for whatever conduct the doctor could anticipate a patient might engage in after leaving the doctor's office is simply beyond the scope of either conspiracy or aiding and abetting. (Emphasis added.)
> Conant v. Walters, 309 F.3d 629, 635-636 (9th Cir. 2002)

The underlined language, and especially its ambiguity, strongly suggests that the line between protected speech and aiding and abetting is a narrow one. The more activities physicians undertake as they assist patients with certification, the greater the risk that they will be subject to conviction for aiding and abetting. Thus, activities that are not necessary for the physician to perform in order to satisfy the basic requirements of our law – examining the patient and certifying that in the physician’s opinion the benefits of marijuana for the patient will outweigh the risks – may carry an increased risk of prosecution and conviction of the physician. Such activities include downloading the application/certificate from NED’s web site, collecting the $25 fee from the patient, taking on the laborof filling out the certificate for the patient and for a caregiver, and then putting all of this together and sending it to NED on behalf of the patient and caregiver.

The antidote for these problems is clear: (1) Remove the administration of the Medical Marijuana Program from the N.E.D., which largely occupies an enforcement and prosecutorial role, and (2) adopt the changes contained in S.B. 128 which sharply and narrowly reduced the role of the physician in assisting the patient to acquire marijuana. This included specifically permitting patients to download the application form directly from the web site as is done in several other states, notably Oregon.[12]

Both changes will enhance the effectiveness of the program by removing most, if not all, of the reasons, rational or irrational, which we can easily infer have been the reason for the low rate of certification on O’ahu as well as possible undercertification on the other islands.

[12] During discussions at the Taskforce meeting it was made clear that the authenticity of the application/certification could be easily determined simply by comparing the physician’s signature on the medical marijuana certificate with the physician’s signature on file in whatever office is or becomes responsible for verifying the certificate’s authenticity.

It is also clear, from the descriptions of the departmental functions for the DOH[13] and for the Dept. of Public Safety and the NED which are included in the majority's report, that the DOH is clearly and beyond doubt the far more appropriate agency for administering a program as to which the Senate Committee report for the original legislation stated:

> In a recent poll conducted by Honolulu-based QMark Research and Polling, an overwhelming majority of Hawaii voters (77%) are in favor of allowing seriously or terminally ill patients to use marijuana for medical purposes. Your Committee intends to follow the will of its citizens and join other states in this initiative **for the health and welfare of its citizens**.

In addition, the original enabling legislation said

> Your Committee strongly suggests that, should marijuana be legalized for medicinal purposes, every effort should be made to partner with existing national research efforts studying the efficacy of using marijuana for treating the terminally ill and those with debilitating medical conditions.

Again, this research role is included within the purview of the Department of Health, as cited in the Majority Report, but not in that of the Department of Public Safety.

Most other states have placed the responsibility for the Medical Use of Marijuana Program either in their departments of health or human services. *(Table 1)*

Findings on access to Patient Registration Forms. While the working group was not able to agree on the posting of the patient registration form on the NED website so that patients may have access to the forms, it is important to note that other medical marijuana programs post those forms on their websites *(Table 1)* and have thus been able to overcome NED's concerns listed in the majority report.

[13] See the 10 essential public health services cited on page 7 of the Majority's Findings and Recommendations.

Table 1

OVERVIEW OF MEDICAL MARIJUANA PROGRAMS IN THE UNITED STATES

	Alaska	**California**	**Colorado**	**Montana**	**Oregon**
State Agency	Dept. of Health & Social Services; Bureau of Vital Statistics	Dept. of Health Services, though each county has its own program rules and fees	Dept. of Public Health & Environment	Dept. of Public Health & Human Services; Quality Assurance Division	Dept. of Human Services
Applications online	Yes	Yes; Can also verify validity of ID card online	Yes; Can also get updated stats about program	Yes	Yes; Very user friendly site (stats, FAQs, resources)
Cost	$25; renewal: $20	DHS collects $13; other fees vary by county	$110	$100	$55 or $20 if patient receives state health care assistance
Amount allowed	1 oz. of usable marijuana 6 plants total of which 3 or less are mature	8 oz. dried marijuana; 6 mature or 12 immature plants	2 oz. useable marijuana; 6 plants total of which 3 or less are mature	1 oz. dried marijuana; 6 plants	3 oz. usable marijuana; 3 mature & 4 immature plants
Caregivers	Can only be primary caregiver to one patient unless patients are related to caregiver by at least the fourth degree of kinship by blood or marriage	To be primary caregiver for more than one patient, a caregiver must reside in same county as patient(s)	Caregivers not issued ID cards	May be a caregiver for more than one person	Only for one person

Table 1
OVERVIEW OF MEDICAL MARIJUANA PROGRAMS IN THE UNITED STATES
(Continued)

	Maine	Maryland	Vermont	Washington	Nevada
State Agency	No	No	Dept. of Public Safety; Criminal Information Center	No	Dept. of Agriculture (works in cooperation with state DMV)
Applications online	Program does not require application	No applications required	Yes	No applications required, though Washington State Medical Assn. provides a medical authorization form on their website for patients to use	No
Fees	None	None	$100 (offers financial assistance to low income patients)	None	Application $50; Processing & issuing ID card: $150
Amount allowed	1.25 oz. useable marijuana; 6 plants total with no more than 3 plants being mature	Less than 1 oz. of marijuana	2 oz. useable marijuana; 1 mature and 2 immature plants	No more than a 60 day supply	1 oz. usable marijuana; 3 mature & 4 immature plants
Caregivers	Allows caregivers, but not specific as to number of patients one can care for	N/A	Only for one person	Allows caregivers, but not specific as to number of patients one can care for	Only for one person

APPENDIX

THE SENATE S.C.R. NO. 197
TWENTY-THIRD LEGISLATURE, 2005 S.D. 1
STATE OF HAWAII

SENATE CONCURRENT
RESOLUTION

REQUESTING THE DIRECTOR OF HEALTH TO CONVENE A MEDICAL MARIJUANA WORKING GROUP TO MAKE RECOMMENDATIONS TO IMPROVE HAWAII'S MEDICAL MARIJUANA PROGRAM.

WHEREAS, in 2000, the Legislature enacted Act 228 to permit the use of marijuana by seriously ill persons who met certain criteria; and

WHEREAS, Act 228 was enacted out of compassionate concern for those suffering from cancer, glaucoma, HIV, AIDS, and various other ailments for which cannabis can provide relief; and

WHEREAS, nine other states have similar programs that are typically administered by their departments of health; and

WHEREAS, these programs maintain web sites with information for patients, physicians, and caregivers, and some provide outreach services to educate stakeholders on the procedures for registering and other useful information; and

WHEREAS, Hawaii's program is housed in the Narcotics Enforcement Division of the Department of Public Safety which does not provide adequate website information or other forms of outreach; and

WHEREAS, this placement was made out of concern for the security issues surrounding the controlled substance involved; and

WHEREAS, the program does not handle or deal with any marijuana, and there have been no security problems reported; and

WHEREAS, anecdotal reports including a patient survey, indicate that many qualifying individuals find it intimidating to register with a law enforcement entity; and

WHEREAS, similar reports indicate that there is difficulty enlisting physicians to register patients because they are also reluctant to register with a law enforcement entity; and

WHEREAS, many people who could benefit from the medical use of marijuana are intimidated and thereby excluded from its benefits; now, therefore

BE IT RESOLVED by the Senate of the Twenty-third Legislature of the State of Hawaii, Regular Session of 2005, the House of Representatives concurring, that the Director of Health is requested to convene a medical marijuana working group to make recommendations to improve Hawaii's Medical Marijuana program; and

BE IT FURTHER RESOLVED that the Director of Health is requested to chair the medical marijuana working group and to include in the working group the following members:

(1) One representative from the Department of Public Safety;

(2) One representative from the Department of Health;

(3) One representative of the Drug Policy Forum of Hawaii; and

(4) One registered qualifying patient currently in the Medical Marijuana program; and

BE IT FURTHER RESOLVED that the Medical Marijuana working group is requested to:

(1) Make recommendations to and assist the Department of Public Safety to improve the effectiveness of the Department's internet website by providing all relevant information to current and potential qualifying patients, primary caregivers, and physicians regarding the Medical Marijuana program, including:

(A) A detailed description of the required procedures for participation in the program by qualifying patients, primary caregivers, and physicians; and

(B) Specific instructions for these individuals to comply with these procedures;

(2) Seek permission and approval of the Department of Public Safety to modify the Department's internet website accordingly;

(3) Review the operation of the Medical Marijuana program and recommend ways to better and more effectively focus on the medical mission of the program; and

(4) Recommend in which state department the Medical Marijuana would most effectively be placed; and

BE IT FURTHER RESOLVED that the Department of Health and, if necessary, the Information and Communication Services Division of the Department of Accounting and General Services are requested to assist the Department of Public Safety in implementing improvements to the Department's internet website no later than the convening of the Regular Session of 2006; and

BE IT FURTHER RESOLVED that the Director of Health is requested to submit a report of the findings and recommendations of the Medical Marijuana working group, including any necessary proposed legislation, to the Legislature no later than twenty days prior to the convening of the Regular Session of 2006; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Director of Health, the Director of Public Safety, the Executive Director of the Drug Policy Forum of Hawaii, and the Comptroller.

Adopted by the Senate on April 12, 2005 and by the House on May 3, 2005.